# EXHIBIT A.206

(7 of 8)

admitted to the hospital in the past year. The average cost for a day visit was $35, with average costs of $17 in Gaza and $47 in the West Bank (table 6.5). An admission to a hospital cost the household on average to $116 ($39 in Gaza and $163 in the West Bank). Overall, hospital day visits were the most expensive in NGO hospitals. In Gaza private hospitals were most expensive for treatment without admission and government hospitals were the most affordable. For all admissions, private hospitals were the most expensive and military hospitals the most affordable.

**Table 6.5: Average Cost per Hospital Visit by Type of Hospital, 2004**
(exchange rate US dollars)

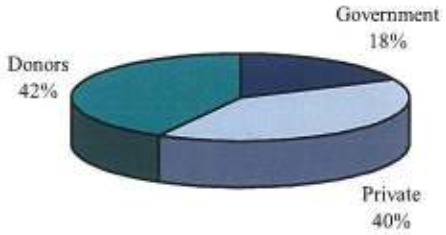
| | Gaza | | West Bank | | Total | |
|---|---|---|---|---|---|---|
| | Day visit | Admission | Day visit | Admission | Day visit | Admission |
| Government hospital | 15 | 37 | 23 | 69 | 19 | 53 |
| UNRWA hospital | 10 | 19 | 26 | 152 | 25 | 121 |
| NGO hospital | 21 | 56 | 157 | 297 | 126 | 275 |
| Private hospital | 45 | 118 | 81 | 340 | 75 | 325 |
| Total | 17 | 39 | 47 | 163 | 35 | 116 |

*Source:* Calculated with PCBS 2004 data.

## 4. Health Financing

Between 2003–04 about 18 percent of all health funds came from the Palestinian Authority, 43 percent came from private households in the form of direct patient payments (including health insurance premiums and fees) and 39 percent came from external donors (figure 6.4).

**Figure 6.4: Health Expenditure by Source of Financing, 2003–04**




*Source:* World Bank staff estimate.

The financial situation of the MOH became increasingly precarious during the second *intifada*. Originally the main sources of government health financing were general taxation, health insurance premiums, fees/co-payments and international funds. After a steep decline in health insurance revenues, financing through international funds became more and more important. For example, in the early phase of the *intifada,* PA Chairman Arafat issued a decree that absolved all *intifada* victims from paying health insurance, including those who

were unemployed because of the Israeli closures. As a result, between 2000 and 2002, the number of households covered by the GHI scheme increased by 207,434, while revenues from premiums declined 26 percent, from $29.5 to $22 million, and co-payment revenues fell. More than half of all persons eligible for health insurance no longer pay for it. Beginning in 2002 health insurance revenues and co-payments increased slightly and by 2004 reached pre-*intifada* levels.

MOH salary and transfer costs are covered by the MOF (with substantial budget support directly to the PA budget from donors). MOF non-salary support to the approved MOH budget has been declining steeply. Donors covered 89 percent of budgeted non-salary operating costs in 2003, with a slightly lower proportion in 2004. The 2003 budget allocation for MOH non-salary operating costs was $51.3 million, equivalent to a 12 percent increase over the 2002 level (table 6.6).[93] This exceeded the available budget and left a financing gap of $5.4 million in 2003. Donor funds have declined, while allocated non-salary budget remains at around $50 million, resulting in an increasing financing gap. The sharpest decline in donor assistance was in 2005, leading to a dramatic financing gap of $35.9 million.

**Table 6.6: Budget Allocation and Revenues for MOH Non-salary Expenditure**
(millions of US dollars)

| | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|
| **Budget allocation** | 49.9 | 45.4 | 51.3 | 51.9 | 50.3 |
| **Revenues** | | | | | |
| Funds received from MOF | 16.1 | 10.3 | 0 | 0 | 0 |
| Funds received from donors | 16.1 | 31.2 | 45.9 | 43.5 | 14.4 |
| Financing gap | 17.7 | 3.9 | 5.4 | 8.4 | 35.9 |
| **Percent financing gap** | 36% | 8% | 11% | 16% | 71% |

*Source:* MOH 2004, 2006.

As a result of the PA's current budget crisis, the MOH accumulated considerable debts to a range of service providers and especially pharmaceutical manufacturers and wholesalers. At the end of 2005 outstanding debts amounted to $38.9 million. The biggest share of outstanding debts (65 percent) was unpaid special treatment referral bills, but the most pressing debts are the ones for unpaid pharmaceuticals and medical supplies. They comprised 31 percent of all outstanding debts in 2005 and providers are increasingly unwilling to deliver these goods without payment.

[93] Donors also provide in-kind assistance (like drugs and medical disposables), which is often not included in the monetary value of donor assistance.

**Table 6.7: Government Health Insurance Contributions**

| Beneficiary category | Monthly premium | Collection system |
|---|---|---|
| 1. Compulsory | 5% of the basic salary—with a minimum amount of NIS 40. The minimum amount is not applied to retired people. | Automatically deducted from the salary and transferred from MOF to the GHI account. |
| 2. Voluntary | NIS 75 per family and NIS 50 for any individual. | To be paid to one of the health directorates in the West Bank or to the post offices in Gaza monthly, every six months or yearly. |
| 3. Workers in Israel | NIS 75 per month—the Israeli Authorities deduct NIS 93 and reimburse only NIS 75 for GHI. Workers should have to pay NIS 93 but have not paid since November 2000. | The Israeli Authority pays the premiums (NIS 75) to the Palestinian MOF on a monthly basis. |
| 4. Contracts[1] | 5% of the overall salary with a minimum amount of NIS 50 and a maximum amount of NIS 75. | Payments are made collectively through the employers on a monthly or yearly basis. |
| 5. Special Hardship Cases | NIS 45 per month per family. | The MOF is making transfer payments from the MOSA budget to the MOH account for all beneficiaries once a year. |
| For all categories | Premiums for additional dependants: NIS 5 per month for each additional dependant. | Amount is included in the monthly premiums. |

[1] This group includes workers registered in the labor union employed in the Palestinian Territories.
*Source:* MOH 2006.

***Government Health Insurance (GHI).*** Enrollment in the GHI is compulsory for governmental employees and voluntary for all other individuals and households.[94] There are five categories of beneficiaries: compulsory, voluntary, workers in Israel, contracts and special hardship cases. Each membership category has different monthly premiums and a varying premium collection system (table 6.7).

In recent years the number of hardship cases and detainees increased steadily (table 6.8). The number of insured workers in Israel decreased. In fact, since the PA's decision to insure all *intifada* victims free, the majority of the insured are not paying premiums. In 2004 there were 148,573 paying families and 169,904 non-paying families insured. This development seriously undermines the MOH's ability to generate revenues. These membership developments are an immediate result of the deteriorating economic situation in the second *intifada*. The number of workers in Israel declined because of border closures and hardship cases increased due to the resulting economic conditions. The only expanding paying group was the compulsory insured, since the number of civil servants increased dramatically in 2003. Table 6.8 contains a comparison of quarter one 2005 and quarter one 2006 data on GHI membership and GHI revenues. The comparison of membership in these two periods confirms the previously described trends: the proportion of special hardship cases and non-paying/exempt families is increasing.

[94] The benefits include primary and secondary health services available through government PHCs, diagnostic centers and governmental hospitals, and tertiary health services available in Egyptian, Jordanian and Israeli hospitals based on referral through the Special Treatment.

**Table 6.8: GHI Membership and Revenue Trends, 1997–2006**

| | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 Quarter 1 | 2006 Quarter 1 |
|---|---|---|---|---|---|---|---|---|---|---|
| **GHI Membership** | | | | | | | | | | |
| Compulsory | 45,542 | 50,937 | 55,963 | 56,767 | 66,139 | 68,736 | 66,618 | 72,756 | 41,777 | 43,456 |
| Voluntary | 36,023 | 14,577 | 15,637 | 15,941 | 9,452 | 9,173 | 2,769 | 4,612 | 2,230 | 2,291 |
| Workers in Israel | 28,878 | 30,200 | 34,539 | 33,830 | 3,189 | 6,136 | 11,700 | 8,054 | 14,741 | 8,408 |
| Contracts | 47,975 | 48,581 | 51,936 | 59,030 | 31,900 | 71,878 | 13,229 | 15,939 | 8,777 | 9,166 |
| Hardship cases (MOSA) | 39,391 | 39,701 | 38,216 | 38,782 | 41,904 | 40,741 | 45,303 | 47,212 | 51,602 | 54,791 |
| **Total paying families** | **197,809** | **183,996** | **196,291** | **204,350** | **152,584** | **196,664** | **139,619** | **148,573** | **119,127** | **118,112** |
| Prisoners (MOD) | | | | | 800 | 1,153 | 1,467 | 1,680 | | |
| Free/exempt families | | | | | 189,934 | 207,434 | 95,449[1] | 168,224 | 79,544 | 82,692 |
| **Total non-paying families** | | | | | **190,734** | **208,587** | **96,916** | **169,904** | **79,544** | **82,692** |
| **Total** | **197,809** | **183,996** | **196,291** | **204,350** | **343,318** | **405,251** | **236,535** | **318,477** | **198,671** | **200,804** |
| **GHI Revenues (in $ million)** | | | | | | | | | | |
| Premium revenue | 32.93 | 34.61 | 33.05 | 30.68 | 20.76 | 20.99 | 25.84 | 30.75 | 10.66 | 8.98 |
| Co-payment revenue | 4.35 | 5.58 | 4.10 | 4.14 | 4.40 | 3.75 | 4.71 | 5.26 | 6.67 | 6.09 |
| **Total GHI revenue** | **37.28** | **40.19** | **37.15** | **48.16** | **25.16** | **24.74** | **30.55** | **36.01** | **17.33** | **15.06** |
| **% of MOH budget coverage** | **39.7** | **46.3** | **41.6** | **50.9** | **27.7** | **28.1** | **25.0** | **27.9** | **11.1** | **8.0** |
| **Memo items** | | | | | | | | | | |
| Exchange rate (NIS/$) | 3.2 | 3.64 | 4 | 4.22 | 4.25 | 4.74 | 4.54 | 4.47 | 4.53 | 4.67 |
| MOH actual budget (in million of US dollars) | 93.9 | 86.8 | 89.4 | 94.61 | 90.74 | 87.97 | 122.03 | 128.86 | 156.51 | 189.0[2] |

[1] Registration shortage in WB.
[2] 2006 planned budget.
*Source:* World Bank staff calculations with MOH and World Bank WDI data, 2006.

For various services provided by MOH facilities the insured have to contribute fixed co-payments. Those include drug co-payments (NIS 3 per item, NIS 1 for children), laboratory co-payments (NIS 1/NIS 6 per test depending if for routine or culture test), co-payments for X-rays (NIS 2/NIS 18 depending if normal or colored), ultra-sounds (NIS 6), CT-scans (NIS 50) and ECGs (NIS 9) and co-payments for services in referral facilities (non-governmental services and services abroad).[95] There are a number of other treatment co-payments for non-MOH facilities, but they have not been enforced since the beginning of the economic crisis in 2000 (table 6.9).

**Table 6.9: Government Health Insurance Co-payments for Treatment in Non-Ministry of Health Facilities**

| Service type | Category of Insured | Co-payment |
|---|---|---|
| Outside MOH in the West Bank and Gaza | • Compulsory insured | 5% |
| | • Social Cases | 10% |
| | • Voluntary insured (continuous payments more than five years) | 10% |
| | • Voluntary insured (continuous payments but less than five years) | 20% |
| | • Voluntary insured (2 to 6 months) | 25% |
| Emergency services | • Voluntary insured (less than 2 months) | 35% |
| Exceptional cases referred by the President | • All insured | 5% |
| Operations like artificial joints, Cesarean sections, bolts, mineral plates, heart beat regulators, arteries support, artificial valves | • All insured | 25% |

*Source:* MOH 2006.

GHI revenues decreased substantially between 1999 and 2002 (table 6.8). Since then they have slowly increased towards pre-*intifada* levels. The total health insurance revenue was the lowest in 2001, at $20.8 million. In 2004 the total revenue reached $36 million. A similar trend could be observed for the GHI revenues as contributions to the MOH budget. The GHI share of MOH budget coverage decreased between 2000 and 2003 from 50.9 to 25 percent. Since then it recovered slightly, to 27.9 percent in 2004, but it remains below the pre-*intifada* MOH budget coverage. In 2005 the total GHI revenues were $35.1 million ($29.8 million in contributions and $5.3 million in co-payments; MOH 2006), slightly less than in 2004. The decline in revenues between the first quarter of 2005 and the first quarter of 2006 is mainly due to a decline in revenues from workers in Israel and the compulsory insured. The number of workers in Israel decreased and government employees, the compulsory insured, had not been not paid since February 2006, thus no deductions for GHI premiums were made from their salaries. Revenues

[95] Exemptions for co-payments are cancer treatment, dialysis and kidney transplantations for children, communicable and infectious diseases and blood diseases (like Haemophilia and Thalasemia).

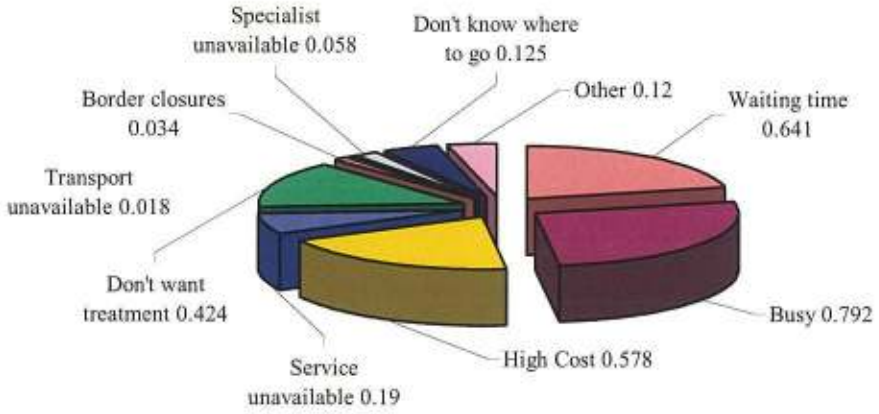
from the voluntary insured improved after the implementation of new regulations that allow no further exemptions from premiums.

## 5. Equity and Efficiency Assessment

***Equity.*** According to the PCBS *Access to Health Services Survey 2003*, conducted between November 2003 and January 2004, Palestinian households have good access to health services. About 94 percent of all households (93 percent in the West Bank and 98 percent in Gaza) had access to a physician where they lived. The physical access to pharmacies was equally good. About 83 percent of all households (97 percent in Gaza and 77 percent in the West Bank) had a pharmacy nearby. In rural areas, coverage was significantly lower, at 63 percent for physicians and 46 percent for pharmacies. Only three percent of people in rural areas lived near a hospital. Generally access to health services was better in Gaza because it is more urbanized than the West Bank.

According to the same PCBS survey, the three main reasons that individuals did not receive necessary medical advice were that they were too busy (79 percent), waiting times were too long (64 percent) or the cost was too high (58 percent; figure 6.5). In the West Bank, high cost was the leading reason for not receiving medical care (68 percent). This was also true for rural areas throughout Palestine (67 percent). This would suggest that a significant segment of the population is unable to access health services for financial reasons, and that financial barriers are more pronounced in the West Bank and rural areas. Since the survey did not report on households' income levels, it was not possible to link financial barriers with income.

**Figure 6.5: Reasons for Not Receiving Needed Medical Consultations, 2003-04**

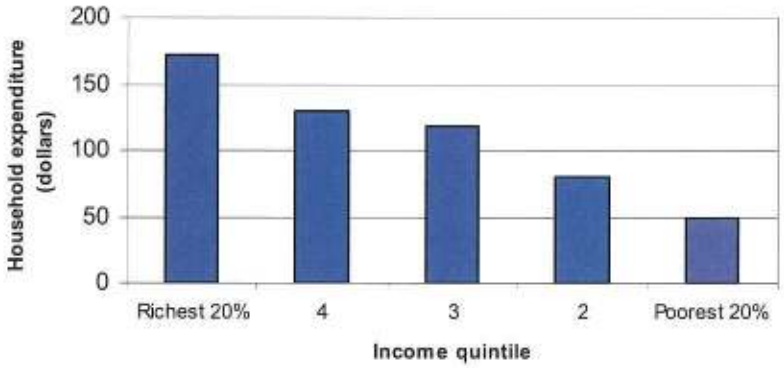



*Source:* PCBS 2004.

The PCBS *Health Expenditure Survey 2004* does provide data on household health expenditure by income level. At all income levels, a high proportion of household income was spent on health. However, the poor in the West Bank & Gaza spent a larger

proportion of their income on health than the rich. In 2004 the average monthly household expenditure on health was $89 in Palestine. The average monthly health expenditure differs greatly between Gaza ($45) and the West Bank ($111). This can be attributed to a higher proportion of rich households in the West Bank and the tendency of households in Gaza to visit health facilities less often. Overall, the richest 20 percent spent $172 on health—about twice the national average and more than three times more than the poorest 20 percent (figure 6.6).

**Figure 6.6: Household Expenditure on Health by Income Quintile in 2004**




*Source:* World Bank staff calculations with PCBS 2004 data.

As a share of total average household spending, the poorest quintile spent an estimated 40 percent of their income on medical expenses, while the richest quintile spent some 15 percent (table 6.10). Because the poor spend a higher share of their income on health, they are more vulnerable to the financial risks associated with ill-health and injuries.

**Table 6.10: Average Household Expenditures on Health by Quintile in 2004**
(in US dollars)

| Income quintiles | Monthly income (NIS) | Average out-of-pocket health expenditure (NIS) | Average income[1] spent on health (%) |
|---|---|---|---|
| Poorest 20% | <1,000 | 212 | 42.4 |
| Second quintile | 1,000–1,900 | 357 | 24.6 |
| Third quintile | 2,000–2,900 | 529 | 21.6 |
| Fourth quintile | 3,000–3,900 | 580 | 16.8 |
| Richest 20% | >4,000 | 770 | 15.4 |

[1] Calculated by averaging over the quintile end-points, for example, for the second quintile: (1,000+1,900)/2. For the poorest 20% the end-points were 0–1,000, for the richest 20% the end-points were 4,000–6,000.
*Source:* World Bank staff calculations with PCBS 2004 data.

***Efficiency.*** The total number of health professionals has continued to expand over the last few years. This trend is illustrated it table 6.11, which compares 2002 and 2004 data. The number of health professionals increased between 2002 and 2004 by 27.4 percent. In 2002 there were 15,233 health professionals in the West Bank & Gaza. In 2004 there were 21,002.

The number of health professionals per 1,000 people also increased. For example, the number of physicians increased by 62 percent, from 1.05 per 1,000 people in 2003 to 1.70 per 1,000 people in 2004. The other group of health personnel that increased significantly in this period was paramedics, from 0.56 to 1.06 per 1,000 people. Only the number of nurses remained stable, at around 1.57 per 1,000 people. The nurse-to-doctor ratio decreased substantially, by 26 percent, between 2002 and 2004, from an already low ratio of 1.54 down to 1.34. These trends reveal a significant imbalance in the health workforce structure and a serious shortage in nursing staff that will likely have negative implications on the cost and quality of care.

**Table 6.11: Health Professionals by Sector, 2002–04**

| | Physicians (including dentists and pharmacists) | | Nurses (including midwives) | | Paramedicals (including health workers) | | Administrative staff | |
|---|---|---|---|---|---|---|---|---|
| | **2002** | **2004** | **2002** | **2004** | **2002** | **2004** | **2002** | **2004** |
| MOH | 1,923 | 2,787 | 2,966 | 3,177 | 909 | 2,199 | 2,775 | 2,898 |
| Non-MOH | 1,638 | 3,378 | 2,349 | 2,548 | 1,005 | 1,653 | 1,668 | 2362 |
| **Total** | **3,561** | **6,165** | **5,315** | **5,725** | **1,914** | **3,852** | **4,443** | **5,260** |
| Per 1,000 people | 1.05 | 1.70 | 1.57 | 1.58 | 0.56 | 1.06 | 1.31 | 1.45 |
| **Memo item** Population (million) | 3.39 | 3.63 | 3.39 | 3.63 | 3.39 | 3.63 | 3.39 | 3.63 |

*Source:* MOH 2003, 2005.

In 2004 there were 77 hospitals with 4,824 beds in Palestine, 57 percent of them in the public MOH sector, 34 percent in NGOs and UNRWA and 10 percent in the private sector. Between 2002 and 2004 the total number of hospital beds increased by 1.3 percent, but the number of hospital beds per 1,000 people decreased from 1.41 to 1.33 partially due to the faster population increase. In addition, the number of hospital beds only increased for MOH and UNRWA hospitals, where most donor assistance was concentrated (table 6.12). As a result, the percentage of hospital beds in the NGO and private sector declined as a share of the total hospital beds

**Table 6.12: Distribution of Hospital Beds by Provider and by Specialization, 2002-04**

| | General hospital | | Specialized hospital | | Rehabilitation hospital | | Maternity hospital | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **2002** | **2004** | **2002** | **2004** | **2002** | **2004** | **2002** | **2004** | **2002** | **2004** |
| MOH | 1,527 | 2,163 | 926 | 572 | 0 | 0 | 150 | 0 | 2,603 | 2,735 |
| NGOs | 1,102 | 1,117 | 252 | 131 | 136 | 157 | 154 | 160 | 1,644 | 1,565 |
| Private | 208 | 196 | 152 | 110 | 0 | 0 | 137 | 155 | 497 | 461 |
| UNRWA | 38 | 63 | 0 | 0 | 0 | 0 | 0 | 0 | 38 | 63 |
| **Total** | **2,875** | **3,539** | **1,330** | **813** | **136** | **157** | **441** | **315** | **4,782** | **4,824** |

*Source:* MOH 2003, 2005.

Between 2002 and 2004 the number of total admissions to MOH hospitals increased by 20 percent, from 224,087 to 278,839, possibly reflecting a shift of patients from NGOs and the private sector (table 6.13). Bed-occupancy rates were around 81 percent in 2004, an increase of 5 percent since 2002. Occupancy rates were about 10 percent higher in the West Bank than in Gaza. The average length of stay was 2.6 days in 2004, reflecting a decrease of 8 percent from 2002. Patients stay on average half a day less in West Bank hospitals than Gaza hospitals.

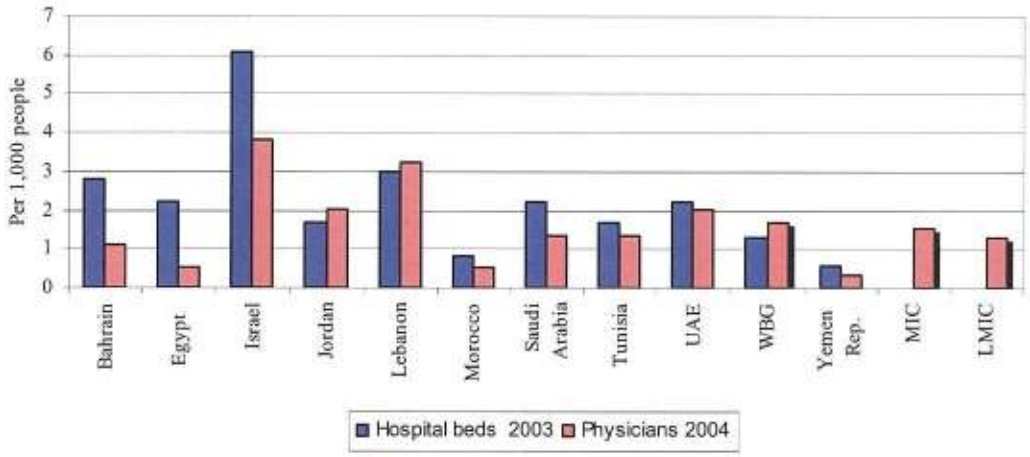
**Table 6.13: Ministry of Health Hospital Utilization Rates, 2002–04**

| | 2002 | | | 2004 | | |
|---|---|---|---|---|---|---|
| | West Bank | Gaza | All | West Bank | Gaza | All |
| Hospital admissions | 101,138 | 122,949 | 224,087 | 127,755 | 151,084 | 278,839 |
| Bed-occupancy rate (%) | 81.4 | 73.8 | 76.7 | 88.6 | 79.4 | 81.1 |
| Average length of stay (days) | 2.50 | 3.00 | 2.80 | 2.34 | 2.89 | 2.60 |

*Source:* MOH 2003, 2005.

An international comparison of the number of physicians and hospital beds per person indicates that the West Bank and Gaza have human and capital resources that are comparable to those of other middle income countries in the region (figure 6.7). These figures do not reflect the efficiency or the quality of services rendered.

**Figure 6.7: Physicians and Hospital Beds Across MENA Countries, 2003 and 2004**




*Source:* World Bank, WDI database and MOH 2005.

## 6. Challenges and Opportunities for Action

The current fiscal crisis presents a major challenge for the already over-extended Palestinian health system. Bold measures are needed to address the structural constraints in the system and to mobilize substantial resources to meet the basic and urgent health needs of the population. Box 6.4 below summarizes the main recommendations for action.

## Box 6.4: Health Policy Recommendations

***Strengthen Health Policy, Planning and Coordination:***

- Develop a broad policy framework that will support an effective coordination mechanism among all the key stakeholders and make the most effective use of the limited available resources. Such a framework would also help donors to align their assistance with the local priorities, avoid duplication and ensure a measure of stability and predictability in the flow of resources for the priority services and programs. It should also promote an efficient allocation of resources that optimizes the complementarity of services among MOH/PA, UNRWA and NGOs/private sector providers.
- The PA and the donor community should continue to support the development of institutions and organizational capacities (like the GHI system) that will be essential in the future for mobilizing, planning and managing resources in the health sector.

1.

2. ***Improve Budget Planning and Fiscal Management:***

- The MOH needs to address its internal staffing structure, and to achieve a better balance between staffing and non-staffing operating expenditures. It should develop a strategic manpower plan for the sector to avoid ad-hoc recruitment.
- The MOH needs to coordinate closely with the Ministry of Planning to develop a realistic medium term public investment plan with adequate allocation of operating and maintenance budget to ensure effective returns on investments.
- The MOH needs to manage its commitments and introduce the principles of accrual accounting to monitor and track any outstanding revenues and payments and avoid the accumulation of arrears.
- The MOH needs to introduce greater transparency in the allocation and use of public resources, which will help to create an environment that will encourage and reward better performance through greater accountability. To this end, the MOH will need to invest in its internal accounting and financial management systems, strengthen its procurement procedures and develop institutional capacity to design and manage contracts.

***Develop Strategic Purchasing Capacity:***

- The MOH needs to develop effective provider payment systems and upgrade its management information system to achieve a better alignment of incentives with performance.
- For services provided directly through MOH facilities, the Ministry needs to improve the timeliness and accuracy of financial data provided to line managers.
- For services contracted through Special Treatment Referrals, the MOH needs to develop more rigorous criteria for prioritizing services which should be outsourced Contracts should include appropriate quality measures and technical audits to ensure adherence to those standards.

***Specific Programs:***

- *Refocus Attention on Public Health Programs.* The emergency situation and difficulties in mobility have severely limited access to preventive care, including early screening and participation in health promoting activities. These conditions will likely increase morbidity rates due to late diagnosis and treatment of illnesses, which in turn will increase the cost of care. Refocusing attention on public health programs that emphasize preventive care would help to alleviate some of the long-term negative consequences of these problems.
- *Develop a Comprehensive Drug Policy.* In the face of constrained resources and limited access to health services, the availability of affordable, safe and effective drugs takes on a greater importance. A comprehensive drug policy should be developed that addresses the critical elements of the pharmaceutical sector, including pricing, registration, quality assurance, distribution and appropriate use.
- *Revitalize the Quality Improvement Program.* In order to counter the negative effects of recent years, and prevent deterioration in the quality of care, the MOH should continue to invest in quality improvement programs that focus on both the people and the institutions, including the development of a system of accreditation for service providers, and continuing medical education programs for health care professionals.

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# CHAPTER 7: SOCIAL POLICY AND SOCIAL SAFETY NETS

## 1. Key Issues and Challenges

A top policy priority for the Palestinian Authority has been to ensure social protection for Palestinians. This is the goal underlying the first of four national programs identified in the 2005–07 Medium Term Development Plan. Social protection is provided in West Bank and Gaza through a complex web of programs supported by the PA, international donors and NGOs and charitable organizations. Diverse sources of safety net and welfare programs are common for most countries of the world. In the West Bank and Gaza, the combination of complicated political and socioeconomic circumstances, the relatively small population and the huge donor presence make the need for cooperation between providers especially important. Given the limited financial resources of the PA and the massive social assistance requirements, it is critical that all available support be well targeted to those most in need. More efficiently designed and administered programs will allow the PA to make the best use of limited funding in this area to ensure that as many resources as possible are directed towards those who truly need them.

Unfortunately there is very little immediate guidance available in the current atmosphere, with near total government bankruptcy and severely constrained donor resources. The analysis and recommendations presented here are put forward with a view toward a future when economic conditions and funding for services improve and the efficiency and effectiveness of social protection services is assured for Palestinian citizens.

## 2. Recent Developments

Despite current difficulties, providers of social protection services in the PA have pressed on. Even in the summer of 2006, when civil servants had not been paid since the beginning of the year, the staff continued to report for work. Some social programs are still operating, albeit in a limited form. Food rations from the World Food Program (WFP) continue to be distributed. The United Nations Relief Works Agency (UNRWA) Special Hardship Cases program and other services are functioning. And food rations for newly poor families in Gaza are being issued through contributions from Egypt. The Ministry of Social Affairs (MOSA) is currently working with the World Bank to improve the targeting of social assistance benefits and to link the receipt with the development of children in health and education through a conditional cash transfer under the Social Safety Net Reform Project.

The PA began the process of setting priorities for social protection and other sectors in 2005 with the formulation of a plan for a Social Safety Net Fund and progress on the preparation of the next Medium Term Development Plan. The PA anticipated $240 million in donor support for a quick-disbursing Social Safety Net Fund. The goal of the programs within the fund was to support about 35 percent of the population for one

year.[96] But the funding did not materialize. Even pre-existing programs received sporadic funding in 2005.

### 3. Spending on Social Protection

Total spending on social protection in West Bank and Gaza is difficult to ascertain because of the large number of PA programs and the important role of donor funds and outside interventions. This relationship will be discussed in more detail below. Table 7.1 provides a summary of spending on benefits for the major programs supported directly by the PA, excluding donor funding. In 2004 the PA spent about 3.5 percent of GDP on social protection, with the major items including pension benefits and cash transfers from the Detainee's Fund for the detainees in Israeli jails and their families.[97] Cash transfers were the biggest expenditure in social protection spending, amounting to 1.8 percent of GDP (excluding pensions). In 2005 there was a massive increase in spending. Preliminary estimates are that social protection spending nearly doubled in 2005, to 6.5 percent of GDP. The major source of the increase was the program for Temporary Employment (spending reached five times the level in 2004) and from pensions (nearly two and a half times the 2004 expenditure).

**Table 7.1: Benefit Expenditures for Social Protection Programs Administered by the Palestinian Authority, 2004–05**

(NIS millions)

| | 2004 | 2005[1] |
|---|---|---|
| **Public pension** | 126.6 | 312.1 |
| **Cash transfers** | | |
| Special Hardship Case | 78.1 | 89.2 |
| Temporary Employment | 45.8 | 288.2 |
| Martyrs and the Injured Fund | 46.7 | 82.3 |
| Detainee's Fund | 121.9 | 150.0 |
| **Other services**[2] | 98.7 | 102.7 |
| **NGO support** | 44.0 | 30.0 |
| **Total** | 561.8 | 1,054.5 |
| **Total as share of 2004 GDP** | 3.5% | 6.5% |

1. Estimated or budgeted amounts for 2005.
2. Includes health insurance costs for SHC participants, vocational training for youth and unemployed and shelter and rehabilitation centers for children, elderly and the disabled.
*Source:* Bank staff calculations based on budget and expenditure data from the Ministry of Finance and from the Ministry of Social Affairs, Ministry of Labor, Ministry of Detainees and Ex-Detainees Affairs.

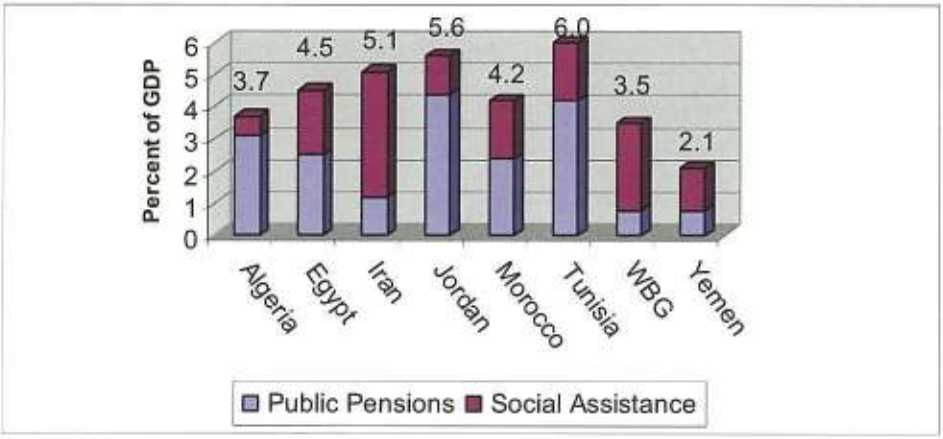
This spending pattern is deceptive, however. Significant PA resources were allocated in 2005 in an effort to scale up cash transfers and social assistance as part of a

[96] The Safety Net Fund had the goal of providing 200,000 families with $100 per month for one year, assuming a family size of 6.
[97] Table 7.1 does not include administrative or operating costs. Spending on social protection in 2004 totals 4.2 percent of GDP if total expenditures for the main ministries providing social protection are included in the table (excluding donor resources).

socioeconomic stabilization plan before the January 2006 elections. For this reason, 2004 levels may be a more appropriate reflection of average expenditure. But even 2004 spending figures are incomplete, given the prominence of international donors. Including budgeted spending on assistance programs from UNRWA, for example, would raise social protection expenditures to 4.0 percent of GDP for 2004.[98]

The PA spends less on social protection programs as a share of GDP compared with other countries in the MENA region (excluding donor assistance). Figure 7.1 shows that general social protection spending on benefits among selected countries in the region has averaged about 4.5 percent of GDP in recent years, with different allocations between social assistance (welfare) and public pensions depending on the country, but with pensions typically accounting for between half and three-quarters of total expenditures. In West Bank and Gaza, slightly over half of current spending is devoted to safety nets. This balance may change rapidly, as recent changes in public sector salaries and new pension legislation are expected to require increased pension payments, as evident in 2005 spending. ven with estimated spending levels of 6.5 percent of GDP in 2005, West Bank and Gaza remains comparable with countries in the region that have not suffered from similar conditions of near constant crisis because of the important role played by outside donors, whose contributions are not reflected in figure 7.1.

**Figure 7.1: Spending Patterns on Social Protection, Late 1990s–Early 2000s**




*Note:* Public pensions spending includes civil service and military pensions where figures available, but excludes private sector pensions. Social assistance includes food subsidies, public works and cash transfers, such as family, maternity and child allowances and compensation to the sick and temporarily disabled. It excludes expenditures on in-kind social services and unemployment insurance.
*Source*: World Bank 2005 and Robalino 2005.

[98] UNRWA budget for 2004 for relief and social services in West Bank and Gaza was NIS 75.3 million ($16.8 million).

## 4. Public Sector Pensions

Pension benefits for former public sector employees represent the largest single source of social protection expenditures. Table 7.1 indicates that NIS 126.6 million ($28.2 million) was paid to beneficiaries in 2004, and this amount is expected to jump to NIS 312.1 ($69.4 million) when final expenditures for 2005 are determined. Future costs are forecast to increase even more. The system is not fiscally sustainable as currently designed and implemented.

***Schemes***. There are currently two pension schemes covering civil servants in West Bank and Gaza. In the Gaza Scheme, the government contributes 12.5 percent of the wage bill and employees contribute 10 percent of wages to the Gaza Pension Insurance Corporation (GPIC). The West Bank Scheme requires a nominal 2 percent contribution from employees, but it is not paid into any fund. Pension benefits are financed directly from the budget. The West Bank Scheme was closed to new entrants in 2001 and all subsequently hired civil servants are added to the Gaza Scheme. Both schemes are considered generous by international standards, with replacement rates in excess of 90 percent of final salaries, liberal early retirement provisions and future increases in pension benefits tied to wage levels, as opposed to a cost of living index.

Palestinian security services personnel have been excluded from the public sector pension system. In January 2005, however, a new Security Services Pension Law (SSPL) was enacted which provides pension coverage to all those 45 years and older in the security services. Like the Gaza system, this law mandates a contribution rate of 22.5 percent of wages (12.5 percent from government, 10 percent from employees), but provides a benefit formula even more generous than the Gaza Scheme's. Retirees can receive 100 percent of their final salary and can be eligible for retirement at 40 years old. Since there are no pension assets, and nearly all those covered will be eligible for retirement upon the law's full implementation, all expenditures under the SSPL must be met from the PA's revenues, not from any built-up assets in the fund.

***Financing and Arrears***. The PA has made only sporadic contributions to the system, though pension benefits have been paid consistently. The outlays from the budget have been reduced by running arrears to GPIC and using the fund's financial assets to pay current pensioners. However, as this policy will lead to the depletion of all assets, over time the PA budget will have to directly fund all current GPIC pension benefit expenditures as well as make contributions for the future. To make matters worse, the government has periodically used both government and employee contributions to fund other government expenses. As a result of these practices, MOF has built up arrears to the GPIC, currently estimated at around $253 million.[99] The GPIC fund currently has recoverable financial assets estimated at between $120–$150 million. Given the relatively small number of pensioners, the GPIC's financial assets have been sufficient to pay current benefits. However, the continuing accrual of arrears, the use of pension contributions for other expenditure needs and the generous benefit formula and early

[99] The last financial report of the GPIC that was independently audited was in 2003.

retirement provisions collectively imply that the GPIC fund could be bankrupt within a few years.

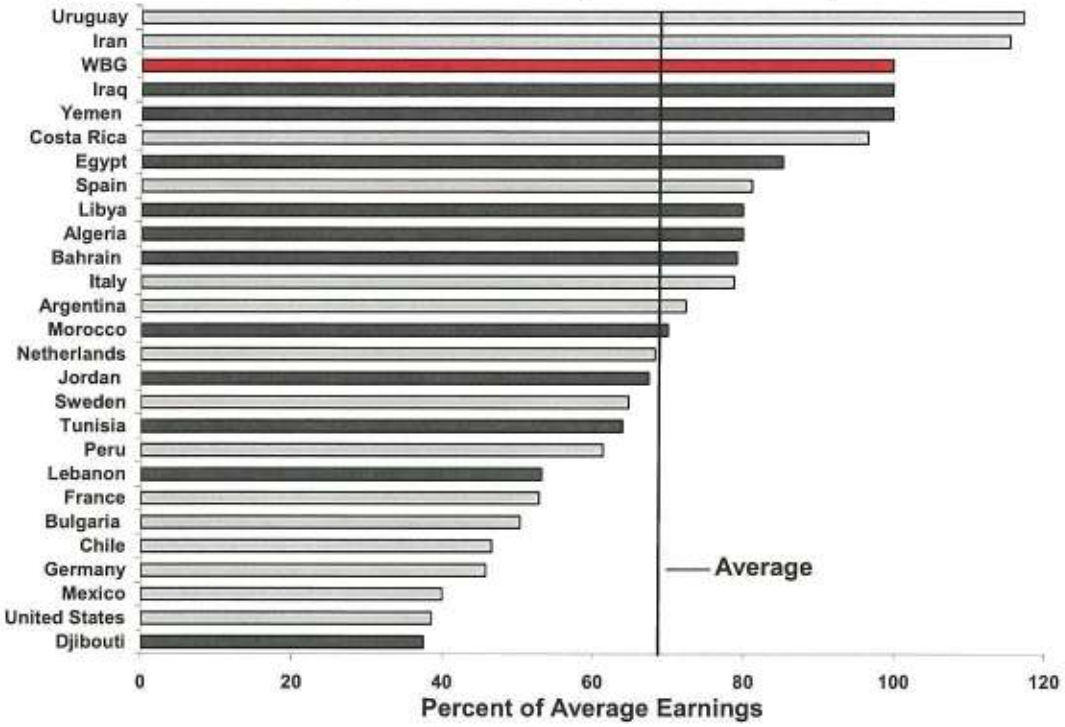
The annual financing burden for public pensions has been estimated at between $140 and $150 million for each of the next five years if all legislated schemes are enforced. This includes paying existing civil service pensions and incorporating the security services. For the civil service alone, before the 2005 wage increases, annual PA costs for the pension system were estimated to be, on average, $65 million a year for the next five years.[100] For the security services under the SSPL, an additional $40 million a year will be required in outlays over the next five years, including for security personnel over age 45 eligible for the scheme (about 6,800 individuals). If the rest of the security services personnel were part of the Gaza scheme, it would add another $40 million.

Taken together, West Bank and Gaza offers its public sector employees one of the most generous schemes in the world in replacement rates, as shown in figure 7.2. This is particularly striking because the vast majority of private sector workers have no pension coverage at all. Current Bank estimates suggest that the current system has accrued liabilities to date worth NIS 32.9 billion ($7.3 billion), over 180 percent of 2005 GDP. This stock of implicit debt, the current value of the future liabilities of the system, is among the highest in the world.

**Reform Efforts**. Pension reform has been high on the public policy and fiscal agenda in the West Bank and Gaza since 2003, when the PA became aware of the looming crisis. With the backing of the international donor community, the PA committed itself to a serious effort to reform its public sector pension system starting with the establishment of a broad-based National Pensions Committee (NPC), chaired by the Ministry of Finance, to consider pension policy and institutional reform. Based on the outcome of the NPC's discussions and recommendations, the drafting of the Unified Pension Law (UPL) began in March 2004. The law was intended to launch a new two-pillar system (with both Defined Benefit and Defined Contribution components) to cover all employees, to be governed by a modern, transparent and independent pension agency. Unfortunately, the legislation was progressively weakened as it moved from drafting through the National Pension Committee, the Cabinet, the Palestinian Legislative Council (PLC) Budget Committee and finally the PLC itself. And the passage of the SSPL further derailed the pension reform effort by promising hugely generous pensions to a relatively small group of security services personnel without regard to cost, funding or equity.

[100] Over a 30-year time horizon, PA pension expenditures for the civil service without reform will be at least $150 million annually.

**Figure 7.2: A Global Comparison of Average Pension Gross Replacement Rates**




In addition, considerable pressure was put on the PLC to pass a law providing pension coverage for the private sector. Unlike the public sector, very few workers in the private sector have pension coverage. A small number of limited private schemes exist for certain professions. Palestinians who had regular employment in Israel and contributed to social security schemes there were also entitled to pension payments, though benefit payments from Israel are increasingly undependable.101 A social security law was passed in late 2003, but has not been implemented. The Ministry of Labor, with World Bank analytic support, determined that the law was seriously flawed in both its parametric design and institutional provisions.

Reform of the pension system is possible if the PA makes it a priority and, in particular, addresses the shortcomings in the current version of the UPL. This would include adjusting the parameters, rolling back early retirement provisions and limiting acquired rights. It requires appropriate changes in the legislation to ensure that the system is well-governed and transparent and that financial assets are safeguarded for the benefit of plan participants. To speed the transition, severance payments for older employees of the security and civil services should be considered in lieu of pensions. The UPL provision for a "Citizen's Pension" could provide a useful mechanism for providing social insurance to the elderly, but it needs to be properly targeted and appropriate to the

[101] Unfortunately, Israeli policy has made it difficult for these workers to collect their pensions without first taking action in court.

prevailing fiscal situation.102 A properly designed public pension institution could be expanded over time to cover the provision of private sector pensions. Fundamental reform is not a trivial undertaking, however, especially since new pension legislation has been so recently adopted. Reform should begin in earnest as soon as possible.

### 5. Public Safety Net and Employment Programs

The patchwork nature of social protection programs in West Bank and Gaza emerges due to the variety of safety net and employment programs managed by the PA. The Ministry of Social Affairs is the primary public provider of social safety nets. It is responsible for three programs: the Special Hardship Case program, a vocational training program for disadvantaged youth and in-kind shelter and institutional care for orphans, victims of family violence, the disabled and the elderly. Until 2006 MOSA was also responsible for a fourth program, the Program for the Families of Martyrs and the Injured. The Ministry of Detainees and Ex-Detainee Affairs operates a cash transfer program for current and former detainees of Israeli prisons and their families, and a donor-financed training and microcredit program for former detainees. The Ministry of Labor manages the large Temporary Employment workfare program and a number of technical and vocational training programs. This section investigates each of the largest four programs highlighted in table 7.1, the Special Hardship Case Program, the Temporary Employment Program, the Fund for Families of Martyrs and the Injured, and assistance to detainees and ex-detainees.

***Special Hardship Case (SHC) Program.*** The main public social assistance program is the SHC, which is supported by MOSA with food-aid support from the World Food Programme. It was inherited from the Israeli Civil Administration after 1994 and the design remains essentially the same today. The program provides cash and food benefits to households that are poor and that do not contain an able-bodied working-age male.

Beneficiary families can receive a cash transfer depending on family size, health insurance through MOH and a food ration available several times year, as well as exemptions from paying school fees and assistance for school books. Some families receive full support and others receive only food or insurance. Cash benefits are reduced accordingly if a family receives food or receives support from UNRWA. The value of the total benefit is estimated at about NIS 800 ($178) per person per year (Astrup and Buyuksahin 2005; Ayala and Abdel-Shafi 2002). The SHC benefit represents about 30 percent of the absolute per capita poverty level, or 13 percent of the main poverty line level.

The MOSA program serves about 47,000 families in Gaza and the West Bank, totaling around 155,000 individuals. Determining who should be in the eligible population is difficult given the lack of current data. Using the estimated extreme poverty rate of 16 percent from 2003, there are at least 607,000 very poor people in West Bank and

[102] The law sets the benefit of the Citizen's Pension at NIS [provide value] (US $100) a month with a relatively low age threshold (those 60 and above), making the social pension distortionary and unaffordable.

Gaza. Current conditions may have increased the extent of severe poverty, but this cannot be verified. By the last available measure, SHC program coverage is about one-quarter of the extremely poor population.

Figure 7.3 displays the number of beneficiary families and the total cash benefits disbursed in recent years for the SHC program. It is clear that the number of families receiving assistance has increased dramatically, rising 36.5 percent from the 35,000 families covered in 2001. The level of cash transfers have not quite kept pace, increasing 32 percent between 2001 and 2005 to a current estimated level of NIS 89.1 million. Together, the figures in the graph imply that average cash benefits per family have declined in nominal terms while coverage has expanded.

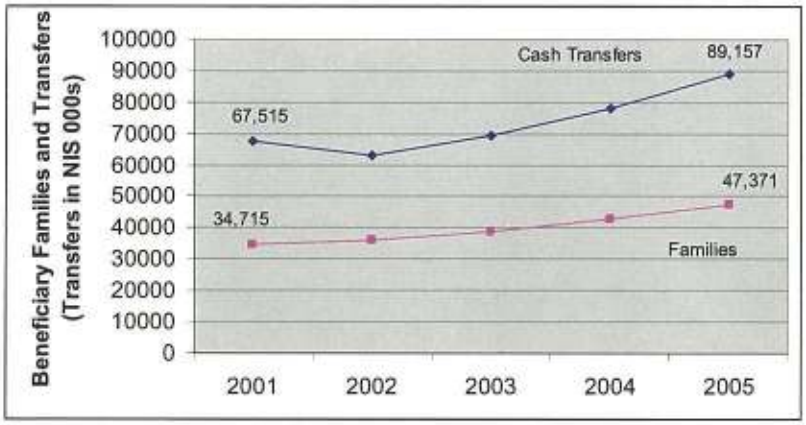
The current targeting properties of SHC benefits are broadly consistent with available international averages, if below what could be achieved. A preliminary assessment using data collected in the spring of 2004 found that 55 percent of the sampled beneficiaries of the program have incomes above the national poverty line (Astrup and Buyuksahin 2005) Similarly, nearly 60 percent of the SHC benefits accrue to non-poor beneficiaries. Evidence from a range of international cash transfer programs suggests that up to 75 percent of benefits can "leak" to the non-poor. Well-targeted programs tend to reduce the leakage rates to between 30 and 40 percent, although it is difficult to draw conclusions across programs given the variation in program design and targeting approaches (Coady, Grosh and Hoddinott 2004). One reason for the higher leakage rates observed with SHC may be the focus on providing benefits to special categories of eligible groups, such as widows, the elderly and those families with a disabled household member. These groups may not necessarily be correlated directly with income poverty. The limited resources available for the MOSA SHC program, along with the relatively large demand for these funds, suggests that improving the targeting of the program should be a priority.

Table 7.2 explores staffing, the wage bill and rudimentary administrative costs for the SHC program. Between 2001 and 2005 the wages and salary bill for all MOSA employees has increased more than 47 percent, far outpacing inflation over the period, but it is modest in comparison with the wage bill of some other ministries and the security services. Staffing increased by about 420 over that period, an increase of 46 percent. The staffing increase is among the highest experienced in the PA ministries (see chapter 3). MOSA has a much smaller staff than the Ministries of Education or Health, but its increase in staff and salaries has nonetheless contributed to the PA funding problems.

Administrative costs have remained fairly constant over the last four years. Estimated costs for key MOSA programs are about 24 percent of total cash benefits for 2005. Available information does not separate the costs by program, so this figure includes the cost of some in-kind operations of the ministry, including vocational training for youth and institutional care for the vulnerable. This estimate puts the SHC on the high side compared to many cash transfer programs around the world, but it is in line with traditional in-kind programs. Administrative costs for a well-run cash transfer program

are typically between 5 and 10 percent of benefits, while for in-kind food-related programs they can be upwards of 20 percent.

**Figure 7.3: Ministry of Social Affairs Special Hardship Case Expenditures and Beneficiaries, 2001–05**




*Source*: MOSA budget data and SHC program data.

**Table 7.2: Staffing, the Wage Bill and Rudimentary Administrative Costs for the Special Hardship Case Program, 2001 and 2005**

(NIS thousands)

| | 2001 | 2005 |
|---|---|---|
| Cash transfers | 67,515 | 89,157 |
| Salaries | 24,098 | 35,465 |
| Staff | 917 | 1,338 |
| Administrative cost ratio | 26% | 24% |

*Source*: MOSA budget data, SHC program data and staff estimates. Includes some costs for programs other than SHC, including vocational training and institutional care.

In summary, a brief examination of the SHC program reveals it to be a generally well-administered program by international standards, but the targeting should be improved. Administrative costs are high, but do not differ wildly from those of many other programs in other countries. Program coverage is relatively low but coverage should be examined together with the other SHC program administered by UNRWA, as these are in a sense a single program. Benefit levels are roughly in the middle of the range observed across country programs. SHC average benefits are about 13 percent of the poverty line, while typical benefits in most countries range between 5 and 25 percent of the poverty line. Leakage of benefits from SHC to the non-poor is in the high range, at 60 percent of total benefits. Preliminary analysis has shown that changing from the current categorical targeting practices to a proxy means test approach would reduce leakages to the non-poor to between 30 and 40 percent. The World Bank is currently working with MOSA to help improve targeting practices through the Social Safety Net Reform Project.

***Temporary Employment Program (TEP).*** This major employment program was started by the MOF in May 2004 with initial technical and financial support from the International Labour Organization. TEP is now managed by a Temporary Employment Committee under the leadership of the Ministry of Labor with the participation of the MOF, MOSA, the MOA and representatives from labor and the private sector. The program was intended to be the flagship intervention under the proposed Social Safety Net Fund from 2005, but external donor funding did not materialize to expand the TEP as planned. All benefit payments and placements stopped as of January 2006 due to lack of funding.

TEP is a "workfare" intervention that is targeted to the unemployed, offering temporary jobs in the PA, local councils and, to a lesser extent, the private sector. It is not a classic public works program in which beneficiaries work almost exclusively in labor intensive activities. The program places some beneficiaries into public works jobs, but places others in white collar positions in line ministries and the public sector, depending on the background of the individual.

The program draws its participants from among the registered unemployed. As of January 2006 there were over 486,000 unemployed individuals registered on the Labor Market Information System (LMIS) maintained by MOL. Available benefits are allocated geographically based on district unemployment maps maintained by PCBS. Lists of eligible unemployed are drawn up for each region in proportion to the severity of the unemployment problem, then the groups of individuals cycle through the TEP program. The lists are determined based on established criteria, including current unemployment status, occupational qualifications, age, gender and health status. Field workers then check the eligibility of the individuals through cooperation with municipal councils and home visits. Throughout employment, participant compliance is monitored through attendance reports submitted to local unemployment offices and spot checks by field workers to ensure that the individuals are at work.

Originally, each new cycle was three months, and each person on the selected list would work and be paid for this period. At the conclusion of the cycle, a new list of participants would be brought into the program for three months, replacing the previous group. Payment arrears and limited funding resulted in longer lists as the program expanded and the job commitment was reduced to two months. By the last months of 2005, the program had practically become unemployment assistance, with payments made without recipients going to work or MOL checking on employment status. By January 2006 about 200,000 unemployed individuals had benefited from TEP, receiving NIS 334.1 million in beefits.

TEP appears to be generally well run. It has a standardized process for application and a developed LMIS and planning involves major ministries and the private sector in setting standards and verifying eligibility. Improvements in the system and management have been made since the early days of the program under MOF. The creation of beneficiary lists of the unemployed should be more transparent, as it is possible that program administrators could choose beneficiaries in a subjective or discriminatory manner, perhaps selecting those with particular characteristics, leaving less impressive candidates

without jobs and benefits for longer. Program operations need better monitoring and evaluation. An evaluation of the private sector placement component of TEP has been planned, but implementation was stalled along with major operations.

TEP should continue to be an important employment program as budgetary resources become available. The basic design, linking benefit receipt to productive employment, should be maintained, especially in the private sector. Unfortunately, there are very few private sector opportunities within the West Bank and Gaza at present and the situation is unlikely to change in the near future. Simply building up the supply of ready workers does not create the needed demand for labor.

Therefore, the PA may wish to consider diversifying the program in two main directions. First, TEP could allow for an increased role for the traditional public workfare model. Labor-intensive jobs building needed infrastructure such as roads, water and sanitation facilities and basic construction can help absorb labor productively and possibly develop longer lasting job opportunities in construction trades. The traditional workfare model also avoids pushing the unemployed into an already overstaffed civil service and does not require a formal applicant screening or targeting procedure, as participants self-select based on the offered wage.

Second, TEP could incorporate a microcredit component to stimulate private sector small business development. Prior to the start of the second *intifada*, Palestine for Credit and Development (FATEN) and UNRWA had well-established microcredit programs. While FATEN was still relying mostly on group lending to poor communities, UNRWA's program was undertaking individual lending and was financially sustainable (UNCDF 2004). These experiences may hold lessons for the PA, perhaps even leading to direct support or partnering with successful lenders and encouraging some beneficiaries of TEP to seek microcredit through able NGOs.

The Ministry of Labor also runs vocational and training centers geared to the unemployed. These run in parallel to those operated by the Ministry of Social Affairs for disadvantaged youth. The coordination and consolidation of training programs should be considered to avoid needless duplication.

***Fund for Families of Martyrs and the Injured.*** This program was managed from within MOSA, but was separated into a distinct program of the PLC beginning in 2006. Cash transfers are provided to the families of martyrs and those injured during the conflict with Israel. The program served between 6,000 and 7,000 families from the late 1990s through 2003. Between 2004 and 2005 the number of families increased rapidly, reaching 10,630 families in 2005. Average benefits also increased dramatically. The average benefit per family in 2005 was estimated at about NIS 7,750, up from NIS 5,000 in 2004. As a safety net program, the Fund for Families of Martyrs and the Injured is generous. Even the average benefits in 2004 were more than 20 percent of the contemporary poverty line; in 2005 they were 33 percent of the poverty line.

Very little is known about the operation of the Fund. It is not known how many of the recipient families are poor, nor the specific criteria for eligibility. Administrative costs are not readily available, even from MOSA, since their costs are not broken down by program. The program is clearly not targeted to the poorest households. While some assistance should be directed to this population, the level of resources devoted to the Fund for Martyrs and the Injured does not seem justified from a welfare or fiscal perspective. In 2005, for example, the Fund is estimated to have commanded nearly the same level of resources as the entire SHC program.

***Assistance to Detainees and Ex-Detainees***. At the end of 2005 there were about 8,800 Palestinians inside Israeli detention centers (PMA 2006). The families of approximately 6,300 received monthly benefits from the Ministry of Detainees and Ex-Detainees Affairs. These include monthly payments to families of detainees, transfers to detainees inside prisons through Israeli authorities, health insurance for detainee families, medical treatments for children of detainees and lawyers' costs associated with legal proceedings in Israel. Ex-detainees are entitled to a monthly pension that varies depending on the period of detention and can also receive up to six months of unemployment payments. All of these benefits have stopped temporarily since the January 2006 elections. During 2005 monthly expenditures for these benefits averaged about NIS 10.3 million ($2.3 million), or NIS 1,710 ($380) per detainee family. Average benefits are therefore nearly 90 percent of the poverty line, making this the most generous PA program. It is also the most expensive social protection program, and is second only to public pensions in terms of the resources devoted.

Funding for detainees and their families increased over the last several years relative to the larger MOSA programs. Staffing for the ministry has increased by almost 20 percent since 2000, among the larger staffing increases observed within the PA, though still far below MOSA. The total number of staff is modest, at 312 staff members in 2004.

Together with the Fund for Martyrs and the Injured, the programs for detainees and ex-detainees are clearly areas for considering future rationalization and streamlining of services. These two programs alone absorbed more than 1 percent of GDP in 2004, and may have accounted for as much as 1.3 percent in 2005. Yet collectively they provide benefits to fewer than 20,000 families. Certainly from efficiency and fiscal considerations, if not equity considerations, some of these resources could be better targeted.

## 6. International Donors

The international donor community plays a vital role in the provision of social protection services, as it does with education and health services. For example, emergency and humanitarian programs accounted for up to 36 percent of annual donor disbursements between 2001 and 2003.[103] And in 2002 alone, donors disbursed NIS 950 million ($200 million) for food, cash assistance and employment generation programs, more than one and half times the entire transfer budget for the PA in 2004. Most of the operating

[103] Excluding UNRWA programs.

costs of the social ministries, including MOSA and MOL, have been paid in recent years from the donor-financed Emergency Social Services (ESSP) trust fund.

The two largest donors in terms of on-the-ground support and the number of beneficiaries served are the UNRWA and the World Food Program (WFP). In addition to its provision of basic education and health services for registered refugees, UNRWA provides cash assistance and food support through its Special Hardship Case program as well as shelter and rehabilitation services.

***UNRWA Special Hardship Case (SHC) Program.*** The SHC accounts for about one-third of the agency's budget allocated to relief and social services in West Bank and Gaza. For the 2004–05 funding cycle, it is expected that NIS 47.7 million ($10.6 million) will be spent on the SHC program. This is less than half the level of resources typically committed by the PA.

The UNRWA SHC served about 124,600 individuals in 2005, 68 percent residing in Gaza and 32 percent in West Bank. These figures have increased slightly over the past several years, but have not changed dramatically.

Individual beneficiaries of UNRWA's SHC program all receive a quarterly uniform food ration together with a cash subsidy. This differs from the design of the PA program, where benefits vary depending on family size and other characteristics. Table 7.3 summarizes the UNRWA and PA programs in terms of the numbers of beneficiaries and the average value of the benefits. The MOSA program covers more families (and individuals) and also pays nearly double the average UNRWA benefit. This is consistent with the higher MOSA budgets. The table indicates that the majority of the MOSA benefit is in the form of cash, whereas the UNRWA program focuses more on the food subsidy.

**Table 7.3: Special Hardship Cases: Palestinian Authority and United Nations Relief Works Agency Programs, end-2005**

| | MOSA Special Hardship Cases | UNRWA Special Hardship Cases |
|---|---|---|
| Recipient individuals | 154,724 | 124,649 |
| Annual benefit value per capita (NIS) | 800 | 495 |
| Cash | 72% | 36% |
| Food | 38% | 64% |

*Source:* UNRWA Program Budget for 2006–07; World Bank staff estimates.

Together, the SHC programs reach about 279,400 individuals, or 46 percent of those in extreme poverty. This is a respectable coverage rate compared with international experience, provided that the recipients are in fact among the poor. The fact that the eligibility criteria for the two programs is similar, and that the preliminary analysis of the MOSA program suggests high benefit leakages, suggests that MOSA and UNRWA may

wish to coordinate closely on targeting reform. The different benefit packages in the two programs also highlight the need for greater collaboration.

***WFP Assistance.*** WFP emergency programs target the "non-refugee food insecure" population. Support is provided through four types of programs, including general food distribution to the chronically poor, food-for-work/training, institutional feeding and supplementary feeding. Starting in July 2006 WFP estimates that it will increase food coverage from 480,000 to 600,000 non-refugees in response to the escalating humanitarian crisis. This implies increasing distribution from a planned 150,000 tons of food to 190,000 tons, at a total cost of about NIS 450 million ($100 million) over the period September 2005 to August 2007.

WFP uses a geographic targeting approach to identify the most vulnerable communities and those suffering limited job opportunities, limited physical movement and significant destruction of assets. This last group, the so-called "new poor," represents a departure from the past practice of focusing almost exclusively on the humanitarian needs of the chronically poor and disadvantaged. In 2003 WFP provided food to about 367,000 non-refugees classified among the new poor.

About a third of the available resources are devoted to supporting the chronically poor through the Special Hardship Case programs of the PA. About 150,000 chronically poor individuals were provided WFP food rations in 2003, a figure consistent with expectations for 2005. Individuals receive about 2,100 kcal worth of food per person per day, slightly higher than the UNRWA food ration for chronically poor refugees (who are also provided with cash, as noted above).

The assistance of donors such as UNRWA and WFP is critical to provide continuing humanitarian relief and to complement and enhance the PA assistance programs. Even with donor resources, the basic needs of many of the poorest in West Bank and Gaza remain unmet. Making those resources reach as many of the needy as possible requires the most efficient use possible. Coordinating outreach planning, harmonizing targeting approaches and synchronizing benefit packages between the PA and donors can go a long way toward reaching this goal. Many steps have already been taken, including coordinating food resources between the PA, WFP and UNRWA. Donors have also been discussing the value of different targeting approaches toward a more unified approach. But more can clearly be done to improve the efficiency of resource use.

## 7. Private Provision of Assistance

Privately provided social assistance, both in cash and in-kind, is critical to filling the gaps in coverage left after PA and donor support. The two major sources of assistance are NGOs and the families and friends of the needy. Any strategic planning and reforms undertaken must incorporate the private providers and not crowd out their participation.

As of 2005 there were more than 700 international and local NGOs in the West Bank alone, double the number in 1999. Given this diversity, establishing the resources of this

sector is difficult, but a conservative estimate put total funding for NGOs in West Bank and Gaza at NIS 660 million ($150 million) in 2003. Even if the true level is now significantly less, such resources likely exceed all PA transfer resources for public programs.

It is estimated that about half of the NGOs shifted focus from development toward relief and emergency services from 1999 to 2005. This is consistent with a smaller survey conducted during 2003 which found that half of the surveyed NGOs had to reallocate resources away from development programs to emergency response. It is likely this trend will accelerate under the current conditions.

The PA can benefit from explicit coordination with NGOs, both local organizations that have strong ties to the community and large international organizations that have significant operational capacity, such as Oxfam, the International Committee of the Red Cross (ICRC) and Premiere Urgence Palestine, among others. The Ministry of NGO Affairs can serve this role and help support particularly promising NGOs and their projects. In 2005 it is estimated that NIS 30 million ($6.6 million) was provided to NGOs from the PA through the Ministry of NGO Affairs.

Remittances and aid from friends and relatives is also a significant source of assistance, although it appears not to be as important as public assistance, since the effects of the *intifada* sapped personal welfare reserves. In a survey of Palestinian perceptions of socio-economic conditions conducted by PCBS in the summer of 2005, about 11 percent of respondents indicated that social assistance from relatives, friends and neighbors is the most frequently received form of aid. The monthly value of those benefits (NIS 625) ($139) ranked behind only those provided by MOSA among respondents. Surveys conducted in prior years showed a higher percentage of remittance receipt, including a 16 percent rate in late 2004 and 34 percent rate in 2003. These results are not strictly comparable, but are perhaps indicative of a general pattern of declining personal remittances.

## 8. Conclusions and Recommendations

The PA and its social line ministries are operating in an extremely difficult environment. Resources are at best uncertain and are frequently nonexistent. Some services are provided and some benefits are sporadically distributed, though civil servants are still not receiving regular salary payments. Within this uncertain environment, it is all the more important to ensure that the limited resources are well used, realizing available efficiency gains through a combination of greater program and institutional coordination, better policy and program planning and improved targeting of large programs, so that benefits reach the poorest and most vulnerable. Several specific recommendations emerging from the discussion in this chapter are incorporated into box 7.1 below. Many of the recommendations place an equal responsibility on donors, NGOs and the PA for success. All will require strong leadership and accountability from the PA.